Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PREFERRED IMAGING AT THE MEDICAL CENTER
5920 FOREST PARK ROAD
DALLAS TX 75235-6413

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-0273-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 05/10/11, we called and spoke with adjuster, Naomi Mezi to acquire information on compensable body parts and if service needs pre-authorization. She stated that the service is initial and does not require pre-authorization and also claim is non-network, therefore, no pre-authorization requirements. However, the insurance carrier has denied our claim due to no pre-authorization. Our facility has meet the requirements to be reimbursed for the service we have rendered. Please review and settle this matter accordingly so we may receive reimbursement for the service rendered."

Amount in Dispute: $751.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Repeat diagnostic studies require preauthorization. 28 TAC §134.600(p)(8). In the present case, the right hand MRI taken on May 13, 2011 was the second right hand MRI taken. Three upper extremity MRI's including a right hand MRI, were taken in March 2011. The first right hand MRI was taken on march 23, 2011. Thus, the May 13, 2011 was a repeat diagnostic study, and preauthorization was required."

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2011	Upper Extremity MRI – CPT code 73218-RT	$751.85	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorized for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 23, 2011
   - 197-Percertification/authorization/notification absent.
   - 927-Utilization review decision.
   - 930-Pre-authorization required, reimbursement denied.

   Explanation of benefits dated July 11, 2011
   - 197-Percertification/authorization/notification absent.
   - 927-Utilization review decision.
   - 930-Pre-authorization required, reimbursement denied.
   - No allowance change.

Issues

1. Did the disputed upper extremity MRI require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed upper extremity MRI based upon "197-Percertification/authorization/notification absent," and "930-Pre-authorization required, reimbursement denied."

   28 Texas Administrative Code §134.600(p)(8)(A) states "Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline."

   The respondent submitted copies of a report, a bill, and EOB that indicates that on March 23, 2011, the claimant underwent an upper extremity MRI, coded 73218-RT. Then, on March 29, 2011, the claimant underwent a wrist MRI coded 73221-RT. Therefore, the May 13, 2011 MRI coded 73218-RT was a repeat MRI and required preauthorization per 28 Texas Administrative Code §134.600(p)(8)(A). The insurance carrier's EOB denial of "197" and "930" is supported.
2. Because the disputed service was a repeat diagnostic, preauthorization was required per 28 Texas Administrative Code §134.600(p)(8)(A). The requestor did not submit documentation to support preauthorization was obtained; therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/28/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.